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Home > Newsroom > Media Release Database > Fact sheets > 2016 Fact sheets items > Bundled Payments for Care Improvement Initiative (BPCI)

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Bundled Payments for Care Improvement Initiative (BPCI) (Updated from August 13, 2015)

Overview

The Bundled Payments for Care Improvement initiative (BPCI) is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

Background

Bundled Payments

Traditionally, Medicare makes separate payments to providers for each service they perform for beneficiaries during a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. It also rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work closely together across all specialties and settings.

The Innovation Center

The Bundled Payments for Care Improvement initiative was developed by the Center for Medicare & Medicaid Innovation (Innovation Center). The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries.

Initiative Design

The Bundled Payments for Care Improvement initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care.

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs; all acute patients	Selected DRGs; hospital plus post-acute period	Selected DRGs; post-acute period only	Selected DRGs; hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

In Model 1, the Episode of Care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule. The first cohort of Awardees in Model 1 began in April 2013 and concluded on March 31, 2016. The remaining Awardee will conclude its participation on December 31, 2016.

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under this payment model, Medicare continues to make fee-for-service payments to providers and suppliers furnishing services to beneficiaries in Model 2 and Model 3 episodes. At the time of reconciliation, the total expenditures for all related services under a DRG for a beneficiary's episode are reconciled against a bundled payment amount (the target price) determined by CMS. A payment amount is then shared with the Awardee by CMS, or a recoupment amount is then paid by the Awardee to CMS, reflecting the aggregate performance compared to the target price.



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In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. In general, physicians and other practitioners are paid by the hospital out of the prospective bundled payment amount. The first cohort of Awardees in Models 2, 3, and 4 began in October 2013.

As of April 1, 2016, BPCI has 1522 participants in Phase 2. The 1522 participants are comprised of 321 Awardees and 1201 Episode Initiators actively involved in care redesign. The breakdown of participants by provider type is as follows: Acute Care Hospitals (385), Physician Group Practices (283), Home Health Agencies (99), Inpatient Rehabilitation Facilities (9), Long-Term Care Hospitals (1), and Skilled Nursing Facilities (681). The difference between the totals in participants and providers is due to the fact that there are Awardees that are not initiating clinical episodes and therefore not included in the breakdown of participants by provider type.

Participants by Models (Awardees and Episode Initiators)

Model 1 – 1

Model 2 – 649

Model 3 – 862

Model 4 – 10

Over the course of the initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare. Plans for all models include provider-led care redesign and enhancements, such as reengineered care pathways using evidence-based medicine, standardized operating protocols, improved care transitions, and care coordination. All Awardee plans may also include proposals for gainsharing among provider partners.

Models 2, 3, 4 – Two Phases of Implementation

Implementation of Models 2, 3, and 4 was divided into two phases. Phase 1, also referred to as “the preparation period,” was the initial period of the initiative, during which time CMS shared data with participants as they prepared for possible implementation and assumption of financial risk. During Phase 1, CMS worked with participants and their partners through education and shared learning activities to prepare for Phase 2, the period of performance, or “risk-bearing implementation” period.

On January 31, 2013, the first cohort of Bundled Payments for Care Improvement initiative participants were announced. By October 1, 2013, some BPCI participants entered into Agreement with CMS, at which point they began Phase 2, bearing financial risk for some or all of their clinical episodes. In November 2013, CMS offered a second Open Period for current Awardees to add additional Episode Initiators or clinical episodes in BPCI. CMS offered a third Open Period in the winter of 2014 seeking additional organizations to participate in BPCI. The Open Period ended on April 18, 2014 and resulted in many new participants joining the BPCI initiative through the summer and fall of 2014.

In December 2014, a timeline for transition to Phase 2 of BPCI was instituted. According to the timeline, every episode initiating organization, regardless of whether the Episode Initiator is directly bearing risk (as an Awardee) or is participating under an Awardee Convener, had to transition at least one clinical episode to Phase 2 by July 1, 2015 in order to remain in BPCI. The transition of all clinical episodes for all participants into Phase 2 was completed on September 30, 2015, at which point Phase 1 of BPCI ended.

Phase 2 was previously scheduled to end after each participant completed a three-year period of performance for each clinical episode entered into Phase 2. Participation in the BPCI initiative will be extended up until September 30, 2018 for all BPCI Model 2, 3, and 4 Awardees that choose to sign an amendment extending their period of performance for all clinical episodes.

Model 1: Retrospective Acute Care Hospital Stay Only.

In Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule. Model 1 participation includes all DRGs for the eligible beneficiaries. As of April 1, 2016, Model 1 has 1 participant, an acute care hospital. This Model will end on December 31, 2016.

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care.

In Model 2, the episode of care includes a Medicare beneficiary's inpatient stay in the acute care hospital, post-acute care, and all related services during the episode of care, which ends either 30, 60, or 90 days after hospital discharge. Awardees select up to 48 different clinical episodes to test in the model.

As of April 1, 2016, BPCI Model 2 has 649 participants in Phase 2. The 649 participants are comprised of 198 Awardees and 451 Episode Initiators actively involved in care redesign. For Model 2, Episode Initiator means an acute care hospital or a physician group practice that triggers an episode of care. The breakdown of participants by provider type is as follows: Acute Care Hospitals (375), and Physician Group Practices (234). The difference between the totals in participants and providers is due to the fact that there are Awardees that are not initiating clinical episodes and therefore not included in the breakdown of participants by provider type.

Model 3: Retrospective Post-Acute Care Only.

In Model 3, the episode of care is triggered by a Medicare beneficiary's acute care hospital stay and begins at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care

hospital or home health agency. The post-acute care services included in the episode of care must begin within 30 days of discharge from the inpatient stay and end 30, 60, or 90 days after the initiation of the episode of care. Participants can select up to 48 different clinical condition episodes to test in the model.

As of April 1, 2016, BPCI Model 3 has 862 participants in Phase 2. The 862 participants are comprised of 113 Awardees and 749 Episode Initiators actively involved in care redesign. For Model 3, "Episode Initiator" means a post-acute care Medicare provider that triggers an episode of care, or a physician group practice that triggers an episode of care. The breakdown of participants by provider type is as follows: Skilled Nursing Facilities (681), Home Health Agencies (99), Inpatient Rehabilitation Facilities (9), Physician Group Practices (49), and Long-Term Care Hospitals (1). The difference between the totals in participants and providers is due to the fact that there are Awardees that are not initiating clinical episodes and therefore not included in the breakdown of participants by provider type.

In both Models 2 and 3, the bundle includes physicians' services, care by post-acute providers, related readmissions, and other related Medicare Part B services included in the episode definition such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies; and Part B drugs. A target price is set based on historical fee-for-service payments for the participant's Medicare beneficiaries in the episode including a discount. Payments are made at the usual fee-for-service payment rates, after which the aggregate Medicare payment for the episode is reconciled against the target price. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee and may be shared among their provider partners. Any expenditure that is above the target price is repaid to Medicare by the Awardee.

Model 4: Acute Care Hospital Stay Only.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners are paid by the hospital out of the bundled payment. All services furnished during related readmissions for 30 days after hospital discharge are also included in the bundled payment amount. Participants select up to 48 different clinical episodes. As of April 1, 2016, the BPCI Model 4 has 10 participants in Phase 2. The 10 participants are comprised of 9 Awardees and 1 Episode Initiator. There are 9 Acute Care Hospital providers. The difference between the totals in participants and providers is due to the fact that there are Awardees that are not initiating clinical episodes and therefore not included in the breakdown of participants by provider type.

Beneficiary Choice

Beneficiaries can always choose to receive care from providers not participating in the BPCI initiative. Beneficiaries retain their full original Medicare benefits. The initiative does not restrict the ability of beneficiaries to access care from participating or non-participating providers. The care redesign efforts are expected to improve quality of care while lowering the cost of care to Medicare.

Evaluation and Monitoring

CMS is committed to ensuring that beneficiaries receiving care from providers participating in BPCI receive high quality care. To that end, CMS is actively monitoring the quality of the care beneficiaries receive. CMS is analyzing quality information available from claims and quality reporting from the Awardees, as well as surveys and patient assessment tools to assess care experience and health outcomes. CMS' monitoring effort aims to identify quality improvements, including process improvements, changes in outcomes, and reductions in expenditures, and to detect inappropriate practices including care stinting, patient selection to maximize financial gain, and cost shifting. Participants are required to comply with and participate in Evaluation and Monitoring activities and data collection efforts.

The CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report was issued on February 2015, and is available on the CMS Innovation Center website at <http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf>. The Annual Report 2014 Evaluation and Monitoring of the Bundled Payments for Care Improvement Model 1 Initiative was issued on July 2015, and is available at: https://downloads.cms.gov/files/cmmi/BPCIM1_ARY1_Report.pdf.

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